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No. 99-1383

Supreme Court, U.S.
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In the Supreme Court of the United States

U.S. HEALTHCARE, INC.,
Petitioner,

v.

STEVEN BAUMAN AND MICHELLE BAUMAN,
Individually and as Administrators *ad prosequendum*
of the Estate of Michelina Bauman, deceased,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

REPLY BRIEF FOR PETITIONER

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REPLY BRIEF FOR PETITIONER

We demonstrated in the petition that the lower courts are in hopeless disarray on the question of when a tort action against an HMO may be removed to federal court because of complete preemption under ERISA Section 502(a). Respondents themselves concede the importance of the question. See Br. in Opp. 13. Rather than acknowledging that the lower courts are profoundly divided on this recurring issue, however, respondents characterize preemption jurisprudence as merely "evolving," *ibid.*, and offer an unsupported distinction to attempt to harmonize the decision below with those of other courts of appeals. Examination of respondents' proposed unifying principle — that a formal request-and-denial is required for preemption — only strengthens the case for review in this Court.

1. As we explained in the petition (at 7-13), the decision below directly conflicts with those of a number of other courts of appeals, which have held that claims challenging benefits determinations like the pre-certification policy here are completely preempted by Section 502(a). As those courts have explained, such claims are in reality actions "to recover benefits due * * * under the terms of [a] plan, to enforce * * * rights under the terms of [a] plan, or to clarify * * * rights to future benefits under the terms of [a] plan." 29 U.S.C. § 1132(a)(1)(B). A determination that a particular course of treatment will not be covered, or that coverage for a hospital stay will be limited to a prescribed length of time, is "part of the process used to assess a participant's claim for a benefit payment under the plan." *Danca* v. *Private Health Care Sys., Inc.*, 185 F.3d 1, 5-6 (1st Cir. 1999). It thus falls under the scope of complete preemption under Section 502(a) even if the challenged conduct involves medical consultation and decisionmaking. *Ibid.*; see also, *e.g.*, *Kuhl* v. *Lincoln Nat'l Health Plan, Inc.*, 999 F.2d 298, 302-303 (8th Cir. 1993); *Jass* v. *Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1488-1489 (7th Cir. 1996).

Respondents acknowledge (Br. in Opp. 7) that determinations made by an HMO "acting in its role as benefits administrator" are completely preempted by Section 502(a). Respondents contend that this case is different, however, because the coverage they now allege they were due was never formally requested and denied. See Br. in Opp. 7.[1] Again and again in their brief (*id.* at 6-11), respondents rely on this alleged distinction to try to smooth over the stark conflict created by the decision below.

Respondents' "distinction," which is newly minted for the benefit of this Court, does nothing to harmonize this conflict. Just as an HMO acts as a benefits administrator when it applies general coverage guidelines to decide whether to approve payment for a particular course of treatment for a patient, so too does it act in its administrative role when it takes the earlier step of adopting those general coverage guidelines. Quite obviously, an HMO cannot conduct utilization or pre-certification review until it has first adopted general guidelines for coverage. If the application of those general guidelines in an individual case is benefits administration subject to complete preemption under Section 502(a) — as numerous courts of appeals have held — then *a fortiori* the adoption of those guidelines must also be subject to complete preemption under that section.

This obvious point is fatal to respondents' attempted distinction (Br. in Opp. 9) between the "process" of utilization or pre-

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[1] Even this distinction, moreover, is facially inapplicable to Count 6, which the district court below held to be completely preempted. Pet. App. 37a. Respondents allege in Count 6 that U.S. Healthcare was negligent in failing to "provid[e] for * * * a visit by a participating provider despite assurances * * * that such a visit would be provided and despite a telephone call on May 18, 1995 from the Baumans requesting this service." Pet. App. 51a. According to that allegation, U.S. Healthcare effectively denied a benefit that respondents had requested (an in-home visit by a participating provider on May 18, 1995).

certification review and the "policy" to cover twenty-four hours of hospitalization following a normal birth. In any "process" of utilization or pre-certification review, there is a general coverage "policy" being applied. See *Danca*, 185 F.3d at 5 & n.5. Indeed, if anything, adoption of the general guidelines ***more*** obviously constitutes benefits administration than does utilization or pre-certification review, since it does not involve quasi-medical consultation or treatment decisions.[2] Cf. *Danca*, 185 F.3d at 5. In any event, however, the former constitutes "benefits administration" at least as much as does the latter, and the distinction respondents rely on has no force.[3]

Respondents' assertion that Ms. Bauman and Michelina Bauman were wrongfully discharged from the hospital as a result of U.S. Healthcare's failure to authorize a general policy of more expansive inpatient coverage following childbirth is functionally indistinguishable from challenges to pre-certification and utilization reviews: both types of challenges attack

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[2] This case is thus similar to *Pegram* v. *Herdrich*, No. 98-1949 (argued Feb. 23, 2000), in that both cases involve cost-containment features that relate to plan design. At the very least, therefore, the Court should defer action on this petition pending the outcome of *Pegram*, as well as a decision on the pending petition for certiorari in *United States Healthcare Systems, Inc.* v. *Pennsylvania Hosp. Ins. Co.*, No. 98-1836, which the Solicitor General urged this Court to hold pending the disposition of *Pegram* and to grant for full briefing and argument on the merits if the issues that petition raises are not fully disposed of in *Pegram*.

[3] Thus the "allegedly negligent decisionmaking" here, though it "may be characterized as medical in nature," and even though it "was not in itself a final 'benefits' determination," "was indisputably part of the process used to assess a participant's claim for a benefit payment under the plan. As such, any state-law-based attack on this conduct would amount to an [impermissible] 'alternative enforcement mechanism' * * *." *Danca*, 185 F.3d at 5-6 (quoting *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 56 (1987)).

conduct that is part of a prospective coverage determination. To put it another way, both kinds of claims challenge an HMO's determinations about "what [a] medical plan will pay for," which are "part and parcel of its [administrative] mandate to decide what benefits are available under [a] plan." *Corcoran* v. *United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir. 1992). The unanimous view of the courts of appeals other than the court below, as we have explained, is that coverage determinations about what an HMO will pay for are completely preempted under Section 502(a). See *Thompson* v. *Gencare Health Sys., Inc.*, 202 F.3d 1072, 1073-74 (8th Cir. 2000); *Hull* v. *Fallon*, 188 F.3d 939, 943 (8th Cir. 1999), cert. denied 120 S. Ct. 1242 (2000); *Danca*, 185 F.3d at 6; *Jass*, 88 F.3d at 1489; *Corcoran*, 965 F.2d at 1332; see also Pet. 8-10. The decision of the court below conflicts with those unanimous holdings.

Respondents argue that this case is not an action to recover benefits because there was never a formal denial of a request for care and they do not frame their claim as one for benefits due. See Br. in Opp. 7. What respondents fail to grapple with, however, is that the claims other courts have found completely preempted under Section 502(a) are never ***framed*** as a claim for benefits due under an ERISA plan, but instead are always pleaded as state-law tort claims. Complete preemption under Section 502(a) is a means of ***recharacterizing*** a plaintiff's claims, usually in a fashion the plaintiff disputes, based on this Court's holding in *Pilot Life*, 481 U.S. at 54, that Congress intended plan administration issues to be resolved through actions under ERISA rather than under the distinct laws of the several States.

2. In an attempt to shore up the *bona fides* of the decision below, and to minimize the stark split between its holding and reasoning and the otherwise-unanimous approach of the lower federal courts, respondents claim support from a set of cases that involved alleged negligent hiring and supervision of physicians by HMOs and/or vicarious liability claims. See Br. in Opp. 12.

According to respondents, these cases — which held that vicarious liability and negligent hiring/supervision claims are not completely preempted under Section 502(a) — support the decision below because, like this case, they involved "no request for and denial of benefits." *Ibid.*

The cases respondents rely on are clearly inapposite. In each, the challenged conduct involved the direct provision of medical services, either by the doctor herself — for whom the HMO was claimed to be vicariously liable — or by the HMO through the hiring and supervision of a physician. For example, certain claims in *Dukes* v. *U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995), were held not to be completely preempted because they were based on the HMO's conduct in "provid[ing], arrang[ing] for, or supervis[ing] the doctors who provide the actual medical treatment." *Id.* at 360. In *Lupo* v. *Human Affairs International, Inc.*, 28 F.3d 269 (2d Cir. 1994), the HMO was claimed to be liable for its negligence in employing a psychotherapist who engaged in negligent treatment of, and misused privileged information from, a plan beneficiary. *Id.* at 272. In *Rice* v. *Panchal*, 65 F.3d 637 (1995), the HMO was claimed to be liable under a *respondeat superior* theory for the alleged malpractice of a plan doctor. *Id.* at 645. In *Giles* v. *NYLCare Health Plans, Inc.*, 172 F.3d 332 (5th Cir. 1999), plaintiffs claimed that the HMO was liable for a physician's failure to diagnose a heart defect on theories of vicarious liability and negligent selection of the physician (and the HMO did not even argue that complete preemption applied). *Id.* at 335, 338-339 & n.15. And in *Pacificare, Inc.* v. *Burrage*, 59 F.3d 151 (10th Cir. 1995), the claim was based on the HMO's alleged vicarious liability for its physician's negligent medical care. *Id.* at 155. Not one of those cases addressed whether Section 502(a) completely preempts a claim against an HMO based on the HMO's decisions about what medical care it would ***pay for*** — *i.e.*, the HMO's plan administration — rather than the HMO's liability for the doctor's negligent provision of medical care or the HMO's own negligent hiring and supervision of the

doctor who provided medical care.[4] Not one, accordingly, provides support for the decision below.

3. Respondents sum up (Br. in Opp. 14-15) by claiming that the Third Circuit "elucidated two tests courts can apply" to see whether a specific claim is preempted. Whatever might be said about whether the tests articulated by respondent would be a sensible overall approach to Section 502(a) complete preemption, they bear little relation to what the court of appeals actually did. As we showed above, the lower court's actual decision and reasoning are irreconcilable with the holdings and analysis of other courts. Without this Court's clarification, these conflicting holdings will lead to even more confusion about the proper scope of ERISA preemption. As one commentator recently noted, complete preemption under Section 502(a) remains a "pandora's box." Comment, *Closing the Lid on Pandora's Box: ERISA Preemption of Tort Actions Against Managed Care Organizations in State Courts*, 54 U. MIAMI L. REV. 373 (2000). Only this Court can close that box, and unify the disarray of the lower courts.

CONCLUSION

The petition for a writ of certiorari should be granted. In the alternative, the petition should be held and disposed of as appropriate in light of this Court's disposition of *Pegram* v. *Herdrich*, No. 98-1949, and *United States Healthcare Systems, Inc.* v. *Pennsylvania Hosp. Ins. Co.*, No. 98-1836.

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[4] Respondents alleged in their complaint that U.S. Healthcare was liable on a vicarious liability theory and on the basis of its alleged negligence "in failing to exercise due care in the selection, supervision, training, and/or monitoring of Dr. Nemeh as a participating provider of health services." Pet. App. 50a. We are not arguing that those claims are completely preempted under Section 502(a).

Respectfully submitted,

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